Exhibit D

CLAIM # YLAC 08271 STATE OF NEW YORK - WORKERS' COMPENSATION BOARD 10/31/2005

EMPLOYER'S REPORT OF WORK-RELATED ACCIDENT/OCCUPATIONAL DISEASE

Send this notice directly to the Chair, Workers' Compensation Board at the address shown on the reverse side within ten (10) days after an accident occurs. ANSWER ALL QUESTIONS FULLY. A copy should also be provided to or retained by your workers' compensation insurance carrier.

Any employer who fails to timely file Form C-2, as required by Section 110 of the Workers' Compensation Law, is subject to a fine of not more than $1,000. In addition, the Board or Chair may impose a penalty of up to $2,500.

TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED - INCLUDE ZIP CODE IN ALL ADDRESSES-EMPLOYEE'S S.S.NO. MUST BE ENTERED BELOW

WCB CASE NO.(If Known)	CARRIER CASE NO.	CARRIER CODE NO.	WC POLICY NO.	DATE OF ACCIDENT	EMPLOYEE'S S.S. NO.
		W	10WN MF5490	08/22/05	050-90-3978

1. (a) EMPLOYER'S NAME: METROPOLITAN OPERA ASSOCIATION
(b) EMPLOYER'S MAILING ADDRESS: LINCOLN CENTER PLAZA NEW YORK NY 10023
(c) OSHA CASE/FILE NO.:
(d) LOCATION (If Different From Mailing Address): LINCOLN CENTER PLAZA NEW YORK NY 10023
(e) NATURE OF BUSINESS (Principal Products, Services, etc.): PERFORMING ARTS
(f) NY UI EMPLOYER REG. NO.:
(g) FEIN - If UI Emp. Reg. No. Unknown: 13-1624087

2. (a) INSURANCE CARRIER: HARTFORD FIRE INSURANCE COMPANY
(b) CARRIER'S ADDRESS: ONE HARTFORD PLAZA HARTFORD CT 06115 ONE HARTFORD PLAZA

3. (a) INJURED EMPLOYEE (First, M.I., Last): JEAN PAUL FOUCHECOURT
(b) ADDRESS (Includes No. & Street, City, State, Zip & Apt. No.): ASKONAS HOLT LIMITED--J THOMAS

ACCIDENT

4. (a) ADDRESS WHERE ACCIDENT OCCURRED: LINCOLN CENTER PLAZA NEW YORK NY 10023
(b) COUNTY:
(c) WAS ACCIDENT ON EMPLOYER'S PREMISES? [X] Yes [ ] No
5. HOUR EMP. BEGAN WORK: [ ] AM [ ] PM
6. TIME OF ACCIDENT: 08:30 [ ] AM [X] PM
7. DEPT. WHERE REGULARLY EMPLOYED:
8. (a) DATE STOPPED WORK BECAUSE OF THIS INJURY/ILLNESS:
(b) WAS EMPLOYEE PAID IN FULL FOR DAY? [ ] Yes [ ] No

INJURED PERSON

9. SEX: [X] Male [ ] Female
10. DATE OF BIRTH:
11. OCCUPATION (Specific job title at which employed): INDEP. CNTRCTR-SINGE
12. DATE HIRED: 01/12/98
13. (a) AVERAGE EARNINGS PER WEEK? $ .00
(b) TOTAL EARNINGS PAID DURING 52 WEEKS PRIOR TO DATE OF ACCIDENT (Include bonuses, overtime, value of lodging, etc.) $ .00
14. (a) EMPLOYEE IS: [ ] Full Time [ ] Part Time
(b) INJURED EMPLOYEE'S WORK WEEK (Check days usually worked.): Mon [X] Tue [X] Wed [X] Thu [X] Fri [X] Sat [X] Sun [X]

NATURE OF INJURY

15. NATURE OF INJURY AND PART(S) OF BODY AFFECTED: 49 FALL, SLIP OR TRIP INJURY
HIP
16. (a) DID YOU PROVIDE MEDICAL CARE? [X] Yes [ ] No
(b) IF YES, WHEN?
17. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? [X] Yes [ ] No
18. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? [ ] Yes [X] No
19. (a) NAME AND ADDRESS OF DOCTOR: UNK UNK
(b) NAME AND ADDRESS OF HOSPITAL: ST. LUKES ROOSEVELT HOSPITAL 111 AMSTERDAM AVE NEW YORK NY 10025
20. (a) HAS EMPLOYEE RETURNED TO WORK? [ ] Yes [ ] No
(b) IF YES, GIVE DATE:
(c) AT WHAT WEEKLY WAGE? $ .00

NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS

CAUSE OF ACCIDENT

21. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)
EE WAS PERFORMING ON STAGE EE WAS PERFORMING ON STAGE

22. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)
WHILE EE WAS PERFORMING ON STAGE, EE FELL FROM PLATFORM AND SUFFERED A CONTUSION OVER THE LT EYE AND SPRAINED HIS HIP.

23. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE. e.g., the machine employee struck against or which struck him/her, the vapor or poison inhaled or swallowed, the chemical that irritated his/her skin. In cases of strains, the thing (s)he was lifting, pulling, etc.

FATAL CASES

24. (a) DATE OF DEATH:
(b) NAME AND ADDRESS OF NEAREST RELATIVE:
(c) RELATIONSHIP:

PREPARATION

DATE EMPLOYER/SUPERVISOR FIRST KNEW OF INJURY: 08/22/05
DATE OF THIS REPORT: 10/31/05

IF FORM IS SUBMITTED BY EMPLOYER, COMPLETE A & B BELOW.
IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A,B,C & D BELOW.

A. EMPLOYEE PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY: LATOYA SERGEANT
B. TITLE: HR ASSOC
TELEPHONE NUMBER & EXTENSION: (212) 799-3100 x2505
C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS:
D. THIRD PARTY CONTACT NAME: LATOYA SERGEANT
TELEPHONE NUMBER & EXTENSION: (212) 799-3100 x2505